TYPHOID FEVER CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 49696 (R2/1-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown

Sex:
- ○ Male
- ○ Female
- ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** - -

Name of ○ **Employer** ○ **School** ○ **Day Care**

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Information

Symptoms:
- ○ Fever . *(degrees)*
- ○ Chills
- ○ Diarrhea
- ○ Abdominal Cramps
- ○ Nausea
- ○ Vomiting
- ○ Muscle Pain
- ○ Eye Swelling
- ○ Rash
- ○ Other, specify:

Date of Onset / /

Duration of Symptoms in Days

Date First Positive Specimen Collected / /

Source of Positive Specimen:
- ○ Stool
- ○ Blood
- ○ Gall Bladder
- ○ Other, specify:

Culture Results:
- ○ Salmonella typhi
- ○ No Positive Culture
- ○ Other, specify:

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Section 2. Clinical Information (continued)

Was Salmonella typhi strain resistant to any antibiotics? ○ Yes ○ No ○ Unknown

If Yes, antibiotic

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code** -

Physician/Hospital Phone - -

Was the patient treated with antibiotics after onset? ○ Yes ○ No ○ Unknown

If Yes, antibiotic

Date started / / **Date ended** / /

Did the patient receive typhoid vaccination within 5 years of illness onset? ○ Yes ○ No ○ Unknown

If Yes, vaccine

Year received

Was the patient hospitalized?
○ Yes ○ No

If Yes, admission date: / /

Discharge date: / /

Hospital:

Did patient die? ○ Yes ○ No

Section 3. Epidemiologic Information

List all commercial food establishments serving ready-to-eat food that the patient patronized during the 30 days prior to illness onset.

1. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

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Section 3. Epidemiologic Information (continued)

2. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

3. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

List all group gatherings where food was served that the patient attended during the 30 days prior to illness onset.

1. **Type of Gathering**

Responsible Person

Phone Number - - **No. of Persons** **Date** / /

2. **Type of Gathering**

Responsible Person

Phone Number - - **No. of Persons** **Date** / /

Section 4. Risk Factors

During 30 days prior to illness onset, did the patient:

Travel outside the United States? ○ Yes ○ No ○ Unknown

If Yes, where

Date of departure / / **Date of return or entry to the U.S.** / /

What was the purpose of travel?

○ Business ○ Tourism ○ Visiting ○ Immigration ○ Other, specify:

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Section 4. Risk Factors (continued)

Drink untreated surface water? ○ Yes ○ No ○ Unknown

If Yes, where

Date / /

Go swimming? ○ Yes ○ No ○ Unknown

If Yes, where

Date / /

Prepare any food for other people? ○ Yes ○ No ○ Unknown

If Yes, where

Date / /

Does the patient know of anyone else who has recently had an illness characterized by diarrhea, fever, or abdominal pain?

○ Yes ○ No ○ Unknown

If Yes, Name

Relationship

Phone Number - - **Onset Date** / /

Was this person exposed to any of the same commercial food establishments, group gatherings, or travel history listed above?

○ Yes ○ No ○ Unknown

If Yes, describe

Section 5. Comments/Follow-Up

Comments:

Investigator Name

Agency

Phone Number - - **Date** / /